***Texas Department of Insurance***
***Division of Workers' Compensation***
***7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645***

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name and Address:**

TEXAS ORTHOPEDIC HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3926

**Respondent Name:**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number:**
M4-09-4215-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "In closing, it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to improper reductions taken by the carrier in this case. The carrier's position is incorrect and in violation of the ACIHFG."

**Amount in Dispute:** $16,951.05

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Texas Mutual Insurance Company received a TWCC-60 from the above-mentioned requester. Please be advised this claim is in the Texas Star Network. (Exhibit 1). Further the requester in this dispute has a contractual agreement with Texas Mutual through FOOCUS/BEECH STREET. (Exhibit 2). The reimbursement from Texas Mutual was subject to the terms of that agreement. For these reasons Texas Mutual believes no additional payment is due and also argues DWC MDR has no jurisdiction regarding this alleged fee dispute."

**Response Submitted by:** Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 3, 2008 through January 9, 2008 | In-Patient Hospital Services | $16,951.05 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

**Issues**

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?

**Findings**

1. This dispute was filed at the Texas Department of Insurance, Division of Workers' Compensation (Division), Medical Fee Dispute Resolution section on December 15, 2008 for resolution pursuant to 28 Texas Administrative Code §133.307.

2. 28 Texas Administrative Code §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care ***not*** [emphasis added] delivered, or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Texas Administrative Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, pursuant to 28 Texas Administrative Code §133.305, and §133.307, the Division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

3. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Health Care*. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307, and medical fee dispute resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

**Conclusion**

For the reasons stated above, the Division concludes that medical fee dispute is not the appropriate venue for resolution of the issues raised by requestor. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | January 19, 2012 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.